Overview of the 3-Tier Managed Health Care Model
And Pharmacy Benefit Manager

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What is the 3-Tier Health Insurance Program?

- The cost of state employee health insurance is rising by over 10% every year. The 3-Tier Health Insurance Program is an innovative approach that will hold costs down by creating incentives for health plans to reduce their costs to the state, and by encouraging state employees to choose the plans that are most efficient in providing quality health care.

- Each plan will be analyzed by the Department of Employee Trust Funds (ETF) to evaluate its true cost of providing benefits under the state employee health insurance program. The most efficient plans will be placed in Tier 1, the moderately efficient plans in Tier 2, and the least efficient plans in Tier 3.

- The amount that employees will be required to contribute to their health insurance premiums will depend on the efficiency of the health plan. The most efficient health plans will be available to employees for the lowest cost. Less efficient plans will cost employees more. This approach creates incentives for health plans to improve the efficiency with which they provide services. Placement in a more favorable tier will help the plans attract and retain members, while reducing their charges to the state.

How is the 3-Tier Health Insurance Program Better Than the Current Program?

The tiered approach will address the following **problems** of the current program, while maintaining or enhancing the competitive pressures of the program.

- "Shadow pricing": Under the current formula, the state pays health plan premiums of up to 105% of the lowest-cost health plan. Any plan that can remain within 5% of the lowest bid is provided at no cost to employees, just like the plan that submits the lowest bid. This formula encourages health plans to bid 5% above what the plans "guess" will be the lowest bid from their competitors. The plan with the lowest bid gains no competitive advantage in attracting members, because the cost of the plan to their members is the same as the cost of more expensive plans. In fact, the current formula discourages plans from being the low cost plan.

- Rewards plans with younger and healthier population: The current formula tends to reward plans that serve younger and healthier populations, leading to rising costs for plans with older or less healthy populations. This led in some cases to plans withdrawing from the state employee health insurance program because they faced ever-increasing adverse selection (attracting less healthy people into the plan). The 3-Tier approach will analyze the risk factors of the populations served by each health plan and will consider the plan's efficiency in light of the population it serves. This will be a more equitable evaluation of the plans than the current formula, which considers only the health plan's cost for providing service, regardless of the population it serves.

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Different employee contribution rate just for residing in a different county: The current formula is calculated on a county-by-county basis. As a result, employees who select the same plan may be forced to pay significantly different out of pocket premium shares, just because they may live in different counties. The 3-Tier approach will be more equitable. Employees will pay the same contribution for any plan within a Tier, even if they live in different parts of the state.

Will There be Different Benefit Levels in Each Tier?

- No. The level of medical insurance benefits will be the same, regardless of the tier to which the plan is assigned. Plans must meet requirements for uniform medical insurance benefits to qualify for participation in the state health insurance program. Individual plans may offer additional benefits, such as dental or vision coverage.

- If different benefit levels were provided, the lower cost/lower benefit level plans would attract people who need the least health care, while the higher cost/higher benefit tiers would attract people who need the most care. This would shift costs to employees with the most pressing health needs, without creating any incentives for plans to operate efficiently.

How Will Employer and Employee Contributions be Determined?

- ETF will negotiate with health plans to determine the premiums that the plans will charge the state and will assign the health plans to tiers based on the outcome of those negotiations.

- Employee contributions to the premiums will be lowest for the plans placed in Tier 1. Contributions will be higher for plans placed in Tier 2, and highest for the plans in Tier 3. These contributions will offset some of the rising costs of health care while encouraging employees to select the most efficient plans. These contributions will also keep pressure on the health plans to submit the lowest possible bids so that they can be placed in the lower cost tiers.

- The 3-Tier program will be most effective through this single health insurance program, which will encompass all nonrepresented and represented state employees.

Will There Be a Tier-1 Health Plan Available for All State Employees?

- Based on current health plan enrollment and ETF's preliminary assessment of health plan efficiency, if the 3-Tier program were in place today, over 81% of all state employees would have a Tier-1 health plan available to them. This percentage may **improve** once ETF negotiates with the health plans that wish to participate in the state program in 2004. The Department of Employment Relations (DER) is working closely with ETF and the Group Insurance Board (GIB) to increase the availability of Tier-1 health plans across the state. As under the present system, there may be a limited number of state employees who reside in locations where there are no qualifying providers. In these areas of the state, the State Maintenance Plan (SMP) is available. The SMP is a self-insured plan as is the Standard Plan and Standard Plan II.

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Will Co-Pays and Deductibles Change Under the 3-Tier Model?

- The GIB establishes these rates based upon extensive analysis to encourage health care consumers to utilize the most efficient and medically appropriate alternatives available to them. There are no plans to revise the current co-pays and deductibles for 2004.

Has the One-Plus-One (2 person family group) Been Considered as an Option Under the 3-Tier System?

- This approach was considered, but it was not adopted because it would not reduce the premiums charged to the state. Premiums for family coverage are currently set at 2.5 times the premium rate for single coverage. The GIB is responsible for setting that ratio, and closely monitors costs to make sure that the ratio remains reflective of costs.

- After analysis of the costs, the GIB has decided not to recommend changes to the current premium structure. This decision is supported by ETF's analysis of the actual health care costs of families consisting of two persons as compared to the costs of families with three or more persons.

- Two person family groups are frequently couples in their 50s and 60s. Health care costs typically increase dramatically for people over 50 years old. Their costs are comparable to family groups with three or more people, who are most frequently couples in their 20s, 30s and 40s. It is often as cheap, or cheaper, to insure larger family groups whose adult members are younger, even though more people are covered.

What Kind of Quality Checks will this New 3-Tier Program Have?

- Wisconsin's state employee health insurance program already incorporates quality reporting requirements into the evaluation of health plans that wish to participate in the state program.

- In addition, the state will begin requiring health plans to collect and report the quality and health outcome data of their hospitals and other providers in a format that was recently approved by the National Quality Forum (NQF). The NQF is a private, nonprofit entity that is developing comprehensive hospital quality measurements and a public reporting strategy consistent with national aims for quality improvement in health care. This information will be shared with state employees through the open enrollment materials and other ETF publications.

When will the 3-Tier Health Insurance Program Become Effective?

- The 3-Tier program is scheduled to become effective in January of 2004. The annual fall open enrollment brochure will provide specific information on each of the qualifying health plans along with their premium rates based upon their tier designation.

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What is the Pharmacy Benefit Manager (PBM) and how will it work?

- The PBM is a third party administrator of a prescription drug program. The PBM manages the relationship between the state, pharmacies, and drug manufacturing companies. PBMs are primarily responsible for processing and paying prescription drug claims. They also negotiate discounts with large drug manufacturing companies, and develop contracts with pharmacies.

- The procedures employees use to fill and acquire prescriptions will be very similar to the current process, including picking up their prescriptions at the pharmacies they currently use. In addition, more options will be provided, such as mail order for some prescriptions.

- PBMs do not manage the prescriptions that are written. The PBM will help the state to negotiate better prices from drug companies and pharmacies, and hold down the dramatic increases in prescription drug costs. Prescription drug cost increases are one of the major contributing factors to the rising cost of health care nationwide.

- Because the claims are processed through the system managed by the PBM, the PBM will serve as a check and balance over harmful drug interactions.

- The PBM will not determine the co-payments paid by employees for prescription drugs. Co-payments for prescription drugs are determined by the GIB. Over the next few months, the GIB will be assessing the current generic and brand name co-payments to see if changes are needed.